

Blood and Blood Derivatives

This section describes the policy and billing instructions for blood and blood derivative products. For additional help, refer to the *Blood and Blood Derivatives Billing Examples* section of this manual.

Designated Blood Donation

Additional payment for the handling of blood designated by the donor for a specific patient is not a Medi-Cal benefit. Claims for this service will be denied.

Blood Derivative Anti-Hemophilia Factors (AHF) VIIa, VIII and IX

The following codes are for Anti-Hemophilia Factors (AHFs) billed by physicians, hospital outpatient departments, pharmacies, clinics and blood banks:

<u>HCP</u> <u>Code</u>	<u>Description</u>
J7190	Factor VIII (antihemophilic factor, human), per IU
J7192	Factor VIII (antihemophilic factor, recombinant), per IU
J7193	Factor IX (antihemophilic factor purified, non-recombinant) per IU
J7194	Factor IX, complex, per IU
J7195	Factor IX (antihemophilic factor, recombinant) per IU
J7197	Antithrombin III (human), per IU
J7198	Anti-inhibitor, per IU
Q0187	Factor VIIa, per IU
Q2022	Von Willebrand factor (complex) per IU

Failure to use the above codes when billing for factors VIIa, VIII or IX may result in claim denial. Other codes such as Z5204 and Z7610 are not to be used when billing for AHF.

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Providers may be reimbursed for the outpatient use of Factor VIIa 1.2 mg (HCPCS code Q0187). Claims billed with code Q0187 must contain medical justification in the *Remarks* area/ *Reserved For Local Use* field (Box 19). Examples of medical justification include but are not limited to:

- Factor VIII or Factor IX inhibitors in excess of 30 Bethesda units
- Factor VII deficiency
- Factor VIII or Factor IX deficient, with a history of anaphylactoid reaction to Factor VIII or Factor IX
- Factor IX deficient; lab test indicates complete deletion or major derangement of the Factor IX gene
- A Bethesda unit level greater than three (3) and the patient is at significant risk of an adverse reaction if given Factor VIII or Factor IX

By Report" Billing

The AHF claims must be billed "By Report." This report must include a valid invoice and a certification statement for each manufacturer or product brand name listed. If two different products are billed, two different certification statements and invoices must be included. This certification statement must also include the National Drug Code (NDC) of the billed product. Reimbursement under this method is based on the lower of the manufacturer's Average Selling Price (ASP) plus 20 percent or the provider's usual and customary charge. Providers should submit claims with their usual and customary charges in the \$ *Charges* field (Box 24F) of the *HCFA 1500* claim form or the *Total Charges* field (Box 47) of the *UB-92 Claim Form*. The ASP price is updated by the manufacturer quarterly.

Note: Recombinant Anti-Hemophilic Factor codes cannot be billed through Computer Media Claims (CMC) when using the "By Report" reimbursement method.

AHF Claim Completion

When completing a claim for AHF reimbursement, providers may bill for all products on one claim line. Or each product may be billed on a separate claim line. Refer to *Figure 1* and *Figure 2* in the *Blood and Blood Derivatives Billing Examples: HCFA 1500* section of the appropriate Part 2 manual.

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Documentation Required on
Invoice Attachments

The following information must be clearly documented on the invoice attached to the claim:

- Manufacturer name
- Product brand name
- National Drug Code
- Units per vial
- Total number of potency units/vials administered
- Total cost for each product

Note: Specifically document this information when billing the same procedure code more than once for the same recipient on the same date of service.

Acquisition Cost
Certification Statement

The following acquisition cost certification statement must be entered exactly as written in the *Remarks area/Reserved For Local Use* field (Box 19) of the claim or on an attachment included with the claim:

"I certify that my acquisition cost of the anti-hemophilia factor claimed here **NDC** _____ is _____ cents per unit. As used here, the term 'acquisition cost' means invoice cost less all off-invoice discounts and rebates except the standard discount for payment by the tenth of the month."

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Blood Derivatives Other
Than Anti-Hemophilia
Factors (AHF) VIII and IX**

Use HCPCS code Z5204 to bill for blood products and blood derivatives (for example, platelets, plasma, granulocytes or red blood cells), with the exception of Anti-Hemophilia Factors (AHFs VIII, IX) and other exceptions specified below.

List the name of the product or derivative being billed, the number of units and the actual acquisition cost per unit in the *Remarks* area/*Reserved For Local Use* field (Box 19) of the claim.

Fresh Frozen Plasma

Use HCPCS code Z5206 for reimbursement of fresh frozen plasma. Billing with any other code may result in claim denial.

Medi-Cal coverage of fresh frozen plasma is restricted to:

- Replacement of isolated coagulation factor deficiencies
- Reversal of warfarin effect
- Massive blood transfusion (although prophylactic administration of fresh frozen plasma does not appear to decrease transfusion requirements in patients who do not have documented coagulation defects)
- Use in antithrombin III deficient conditions
- Treatment of thrombotic thrombocytopenic purpura

Billing Procedures	Indicate the quantity (number of units), size (volume) and actual acquisition cost on the claim so the reimbursement amount can be determined. State the reason for use of the product in the <i>Remarks</i> area/ <i>Reserved For Local Use</i> field (Box 19) of the claim.
Services Not Covered	<p>Fresh frozen plasma should not be used as a volume expander or as a nutritional supplement due to risks accompanying its use. These risks include:</p> <ul style="list-style-type: none"> • Post-transfusion hepatitis • AIDS • Allergic reactions • Volume overload • Alloimmunization
Pheresis	Pheresis, the separation of plasma from the formed elements of the blood by filtration and centrifugation, requires prior authorization when billed fee-for-service and performed either on an outpatient or an inpatient basis.
Plasmapheresis: Primary Treatment	<p>Plasmapheresis may be authorized as the primary treatment in the following diseases:</p> <ul style="list-style-type: none"> • Guillian-Barre Syndrome • Thrombotic thrombocytopenic purpura • Goodpasture's syndrome • Rapidly progressive glomerulonephritis • Anti-glomerular basement membrane disease • Waldenstrom's macroglobulinemia • Multiple myeloma • Protein-bound poisons

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Secondary Treatment

Plasmapheresis also may be authorized when there is documented evidence of far-advanced disease, unresponsive to drug therapy in patients with the following diseases, most of which are thought to be mediated through immune mechanisms:

- Systemic lupus erythematosus
- Rheumatoid vasculitis
- Myasthenia gravis
- Progressive systemic sclerosis
- Hemolytic anemia
- Immune neutropenia
- Immune thrombocytopenia
- Polymyositis
- Idiopathic thrombocytopenic purpura
- Cryoglobulinemia
- Vasculitis, associated with circulating immune complexes, as seen in hypersensitivity disorders and Henoch-Schonlein purpura
- Chronic inflammatory polyneuropathy
- Relapsing polyneuropathy

Cytapheresis	<p>Cytapheresis is covered for the following problems:</p> <ul style="list-style-type: none"> • Acute or chronic leukemia (cell counts more than 100,000) • Thrombocytosis (platelet count more than 1,000,000) • Sickle cell disease in severe crisis, preoperatively or when complicated by pregnancy or priapism
Therapeutic Apheresis: Billing Procedures	<p>CPT-4 codes 36511 – 36516 must be billed with modifier -AG for any type of therapeutic apheresis. Claims for therapeutic apheresis billed with HCPCS code Z5204 (blood products/blood derivatives) will be denied. The approved <i>Treatment Authorization Request</i> (TAR) determines the number of pheresis treatments allowed.</p> <p>HCPCS code Z5204 (blood products/blood derivatives) must be used to bill for blood products (for example: platelets, plasma, granulocytes or red blood cells) collected from donors by apheresis.</p>
"By Report"	<p>Pheresis products and procedures require "By Report" billing. A description of the processing of the product/derivative from the donor and the number of blood units obtained must be indicated in the <i>Remarks area/Reserved For Local Use</i> field (Box 19) of the claim or on an attachment.</p>
Administering Plasmapheresis	<p>All plasmapheresis procedures should be done in a hospital setting, whether on an inpatient or an outpatient basis, with readily available lifesaving equipment. The physician who bills for these procedures should be available to provide help to the plasmapheresis technician or registered nurse at all times during the procedure.</p>

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Use the following HCPCS Level III codes for reimbursement of human albumin.

<u>HCPCS Code</u>	<u>Description</u>
Z5226	5% albumin, human, 10 ml
Z5228	25% albumin, human, 10 ml

Claims for human albumin billed with either HCPCS Level III code Z5204 (blood derivative, other than factor XIII or IX) or CPT-4 code 90799 (unlisted therapeutic, prophylactic or diagnostic injection) will be denied.

Medical Necessity

Albumin codes Z5226 and Z5228 may be billed up to 980 ml of albumin without documenting medical necessity. Claims for albumin greater than 980 ml require medical justification in the *Remarks* area/*Reserved For Local Use* field (Box 19) of the claim.

UB-92 Claim Form: Providers are limited to two digits in the *Service Units* field (Box 46). For claims greater than 98 units (980 ml), enter "99" in the *Service Units* field and document the total amount claimed in the *Description* field (Box 43).

HCFA 1500 Claim Form: Providers may enter up to three digits in the *Days or Unit* field (Box 24G) for claims greater than 98 units (980 ml).

**Blood Irradiation:
Blood Banks**

CPT-4 code 86945 (irradiation of blood product, each unit) with the appropriate split billing modifier must be used by blood banks billing for whole blood or blood product irradiation.

Billing Procedures

When completing the claim form, providers must enter the number of units of blood irradiated in the *Service Units/Days or Units* box and identify the blood product irradiated in the *Remarks* area/*Reserved For Local Use* field (Box 19) of the claim.

**Transfusions:
Blood Banks**

The following code is to be used only by facilities enrolled in Medi-Cal as blood banks:

<u>HCPCS Code</u>	<u>Description</u>
Z5200	Transfusion by blood bank, blood or blood components, independent procedure

“By Report”

This code is considered a global “By Report” procedure requiring a description of the services performed, including:

- Facility room use
- Type and quantity of blood or blood components transfused
- Number of cross-matches performed
- Fee for transfusion service including staff and materials cost
- Saline wash fee

Billing Procedures

Inpatient/Outpatient providers are to bill using facility type “14,” “24,” “34,” “44,” “54” or “64” on the *UB-92 Claim Form* when billing this service. Identify the facility type as a blood bank in the *Remarks* area of the claim.

Medical service providers are to bill using Place of Service code “99” (other) on the *HCFA 1500* claim form. Identify the Place of Service as a blood bank in the *Reserved For Local Use* field (Box 19) of the claim.